

**The Body Balance**

**Patient Present Complaints**

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone \_\_\_\_\_ Cell # \_\_\_\_\_ Social Security# \_\_\_\_\_ Driver Lic.# \_\_\_\_\_  
 Age \_\_\_\_\_ Birthdate \_\_\_\_\_ I I Sex M / F \_\_\_\_\_ Status M S W D \_\_\_\_\_ No. Children \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Years Employed \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_ Referred By: \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_  
 Person Responsible for this Account \_\_\_\_\_ HealthPlan \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

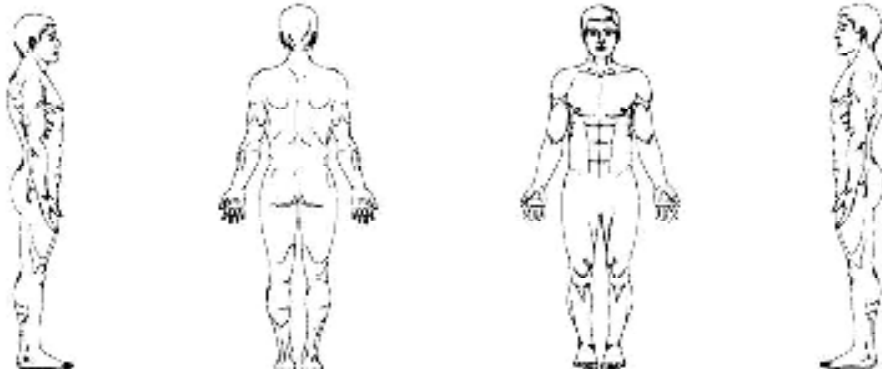
*Please describe your problem and how it began.*

*Date problem began: / /*

How bad is your pain? (Circle a number)	0	1	2	3	4	5	6	7	8	9	10
	No Pain										Unbearable Pain
How often are your symptoms present?	Constantly		Frequently		Occasionally			Intermittently			
Describe your <u>current</u> pain/symptoms:	Sharp/Stabbing			Throbbing			Aches				
	Dull			Soreness			Weakness				
	Numbness			Shooting			Gripping				
	Burning			Tingling			Other _____				
Since it began, is your problem:	Improving			Getting Worse			No Change				
What makes the problem better?	Nothing			Lying Down			Walking				
	Standing			Sitting			Movement				
	Exercise			Inactivity/rest			Other _____				
What makes the problem worse?	Nothing			Lying Down			Walking				
	Standing			Sitting			Movement				
	Exercise			inactivity/rest			Other _____				
Can you perform your daily home activities?	Yes			Yes, only with help			Not at all				
Do you exercise?	Yes, almost daily			Yes, occasionally			Not at all				
Describe your job requirements:	Mainly sitting			Light Labor			Heavy Labor				
Can you perform your daily work activities?	Yes, all activities			Only some			Not at all				
Describe your stress level:	None to mild			Moderate			High				
What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)											

Have you had X-rays, MRI or other tests for this condition? What tests and When? \_\_\_\_\_

**MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING**



Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Patient Name \_\_\_\_\_ Patient ID# \_\_\_\_\_

If you have *ever* had a listed symptom in the *past*, please check that symptom in the *Past Column*. If you are *presently* troubled by a particular symptom, check that symptom in the *Present column*. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

- Past Present Condition**
- Neck Pain
  - Shoulder Pain (R\_\_\_\_\_ L\_\_\_\_\_)
  - Pain in Upper Arm or Elbow (R\_\_\_\_\_ L\_\_\_\_\_)
  - Hand Pain (R\_\_\_\_\_ L\_\_\_\_\_)
  - Wrist Pain (R\_\_\_\_\_ L\_\_\_\_\_)
  - Upper Back Pain
  - Low Back Pain
  - Pain in Upper Leg or Hip (R\_\_\_\_\_ L\_\_\_\_\_)
  - Pain in Lower Leg or Knee (R\_\_\_\_\_ L\_\_\_\_\_)
  - Pain in Ankle or Foot (R\_\_\_\_\_ L\_\_\_\_\_)
  - Jaw Pain
  - Swelling, Stiffness of Joint(s)
  - Fainting
  - Visual Disturbances
  - Convulsions
  - Dizziness
  - Headache
  - Muscular Incoordination
  - Tinnitus (Ear Noises)
  - Rapid Heart Beat
  - Chest Pains
  - Loss of Appetite
  - Anorexia
  - Abnormal Weight
  - Gain    Loss
  - Excessive Thirst
  - Chronic Cough
  - Chronic Sinusitis
  - General
  - Irregular Menstral Flow
  - Profuse Menstral Flow
  - Breast Soreness    Lumps
  - Endometriosis
  - PMS
  - Loss of Bladder Control
  - Painful Urination
  - Frequent Urination
  - Abdominal Pain
  - Constipation/irregular bowel habits
  - Difficulty in Swallowing
  - Heartburn/Indigestion
  - Dermatitis/Eczema/Rash

- Past Present Condition**
- Depression
  - Aortic Aneurysm
  - High Blood Pressure
  - Angina
  - Heart Attack (date) \_\_\_\_\_
  - Stroke (date) \_\_\_\_\_
  - Asthma
  - Cancer, Explain \_\_\_\_\_
  - Tumor, Explain \_\_\_\_\_
  - Prostate
  - Blood Disorder
  - Emphysema (chronic lung disorders)
  - Arthritis
  - Rheumatoid
  - Diabetes
  - Epilepsy
  - Ulcer
  - Liver / Gallbladder problems
  - Kidney
  - Hepatitis
  - Bladder Infection
  - Kidney Disorders (by condition)
  - Colitis
  - Irritable Colon
  - HIV/AIDS
  - Other \_\_\_\_\_

**If a family member has had any of the following, please mark the appropriate box:**

- |                           |                       |
|---------------------------|-----------------------|
| Cancer                    | Epilepsy              |
| Rheumatoid                | Chronic Back Problems |
| Diabetes                  | Chronic Headaches     |
| Heart Problems            | Lupus                 |
| Lung Problems             | Other _____           |
| High Blood Pressure _____ |                       |

Do you have a permanent disability rating?    **Yes**    **No**  
 Location \_\_\_\_\_  
 Date rating received \_\_\_\_\_  
 Rating Percentage \_\_\_\_\_

**Present Weight** \_\_\_\_\_ pounds  
**Height** \_\_\_\_\_ feet \_\_\_\_\_ inches

**Please check any of the following that apply to you.**

- Pregnancy, # births \_\_\_\_\_
- Birth Control Pills, type \_\_\_\_\_
- Medications (list if not listed elsewhere)

- Tobacco
- Alcohol
- Drug or Alcohol Dependence
- Coffee/Tea/Caffeinated Soft drinks:  
cups/cans per day: \_\_\_\_\_

\_\_\_\_\_ Hospitalizations/Surgical Procedures

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages in the future.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Do you have Health Insurance?      *Yes*      *No*

Insurance Company Name \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ I.D. # \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

Relationship to Subscriber:      *Self*      *Spouse*      *Dependent*      *Other* \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

(Guardian Must sign for all patients 17 years old or younger)

